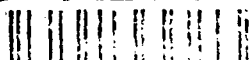


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**ARMY MEDICAL DEPARTMENT OFFICERS IN DIVISION ASSIGNMENTS:
PREPARED TO SUCCEED, OR DOOMED TO FAIL?**

BY

Lieutenant Colonel George Shackleford Robinson
United States Army

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USAWC MILITARY STUDIES PROGRAM PAPER

ARMY MEDICAL DEPARTMENT OFFICERS IN DIVISION ASSIGNMENTS:
Prepared to Succeed, or Doomed to Fail?

AN INDIVIDUAL STUDY
by
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The study's foundation was a survey of 100 former battalion commanders who are students at the US Army War College, Class of 1992. Their opinions of the shortcomings of their AMEDD officers formed the basis for the recommendations for changes to curricula and assignment policy.

This paper is applicable to individuals interested in education and training of AMEDD officers which prepare them for Table of Organization and Equipment (TO&E) unit assignments. The paper is also applicable to those interested in the policies that effect those assignments. A one page summary of the recommendations appears after Conclusions, on page 34.

TABLE OF CONTENTS

ABSTRACT.....	ii
INTRODUCTION	
I. Purpose.....	1
II. Background.....	1
THE STUDY AND FINDINGS	
I. What Skills, Knowledge and Attitudes Are Needed?.....	6
II. How Do AMEDD Officers Perform Now?.....	8
III. Analysis.....	9
IV. Educating Non-AMEDD Officers.....	11
ARMY MEDICAL DEPARTMENT ANSWERS	
I. Training.....	13
A. General.....	13
B. Field Experience is the Best Training.....	15
C. Didactic Training	19
D. Training to Maintain.....	21
E. Training to Train.....	23
F. Training to Lead.....	25
G. New Training Methods.....	27
II. Assignment Policy.....	30
CONCLUSIONS.....	32
RECOMMENDATIONS.....	34
APPENDICES	
A. Skills Knowledges and Attitudes - 67H Career Field.....	35
B. Academic Subjects - AMEDD Officer Basic Course.....	39
C. Academic Subjects - AMEDD Officer Advanced Course.....	46
D. Battalion Commanders Survey.....	53
E. Results of the Battalion Commanders Survey.....	56
NOTES.....	58
BIBLIOGRAPHY.....	60
ILLUSTRATION	
AMEDD Officer Performance in Divisions.....	8

ARMY MEDICAL DEPARTMENT OFFICERS IN DIVISION ASSIGNMENTS:

Prepared to Succeed, or Doomed to Fail?

INTRODUCTION

I. PURPOSE

The author did this study because the Office of the Surgeon General (OTSG) expressed concerns about Army Medical Department (AMEDD) officers in divisional and other Table of Organization and Equipment (TO&E) assignments. The study will provide recommendations to OTSG on innovative methods to prepare AMEDD officers for tactical unit assignments. It also will recommend changes in policies for selection of AMEDD officers for tactical unit assignments.

II. BACKGROUND

In the late 1970s, the concept of multi-functional forward support battalions (FSB) in divisions developed and matured. The idea meant the end of functionally organized division maintenance, supply and transport, and medical battalions. The intended advantages were as follows:

- a. Streamlining the management of all combat service support (CSS) functions under one commander,
- b. One manager of the brigade support area, and
- c. A single coordinator for rear area defense.

The Army conceived the FSB to improve the responsiveness of maintenance and supply systems. It reorganized the three functional CSS battalions into three multi-functional forward

support battalions and a main support battalion. When the Army did this, the divisions lost three headquarters that had a concentration of technical experts that could solve virtually any problem in their respective disciplines. They could train subordinate units and personnel in their technical arts, and provide counsel to commanders on their highly technical functions. Headquarters made up of officers who were each experienced in a single discipline replaced these centers of expertise. The concept assumed that these officers could solve the problems in their specific areas. Combined, this multi-functional team was to ensure that they managed all technical disciplines well. Brigade commanders supported the idea because it simplified coordination for combat service support. It reduced the number of staff contacts required for integrating support and it provided an actual commander who had sole responsibility for CSS. The brigade commander was also able to pass other functions to the FSB commander. There are many, but the most important are:

- a. control of lines of communication,
- b. support coordination for attached, direct support, and general support units in the brigade's area of responsibility,
- c. rear area security.

Unfortunately, the Army did not fully consider the impact on medical operations and the way they are conducted when it made the decision to reorganize into multi-functional battalions. The result was an erosion of medical support capabilities, not an enhancement of them.

One of Murphy's Laws states, "Anything designed to perform multiple functions cannot perform a single function well." ¹ From a medical point of view, this is true of forward support battalions (FSB) and main support battalions (MSB). They usually perform the functions of maintenance, supply and transport better than the medical function because of the imbalance of

expertise at the FSB headquarters. There are few AMEDD officers or NCOs assigned to FSB headquarters. Even fewer Medical Service Corps (MSC) officers achieve command of FSB/MSBs. When each division had a medical battalion, each division had an MSC officer as a battalion commander (as well as an Ordnance officer and a Quartermaster or Transportation Corps officer). Today, there are very few MSCs in command, certainly not one per division. The MSCs have lost their fair share of commands. One reason for the dearth of AMEDD officers in command is that they are ill-prepared to be selected by the Command Selection Board for Multifunctional Commands. MSCs do not have the opportunity to serve in the same types of jobs available to Ordnance, Transportation, and Quartermaster officers. Additionally, the Academy of Health Sciences (AHS) does not have a curriculum to provide the type of training that will make the MSC competitive. On-the-job experience is the only way that an MSC can compete for these commands.

There is a reason for the disparity between the medical functions and those of supply, maintenance, and transport. The latter three are closely related, each sharing systems and philosophies. The newly formed Combined Arms Support Command (formerly the Logistics Center) supervises their doctrine and education curricula. The medical system has always been "different," never integrated with other systems. The medical function has traditionally been a "stovepipe" entity. It had a special system for medical supply and a separate communications system for medical information. It also had a dedicated transportation system for the evacuation of casualties and movement of the medical unit. Although many of these capabilities exists in the FSB concept, flexibility and expertise of the former system do not.

Under the functional battalion concept, the medical battalion headquarters had the ability and authority to adjust medical support across the entire division. It could put assets where the

battle prescribed without regard for unit attachment.² FSB commanders cannot do this. The DISCOM commander must do it. Unlike other CSS units, medics operate on an area support basis³. This is difficult for supply and transport units and nearly impossible for maintenance units. Also, medical units always provide support either directly or generally. They are never attached to other units.

When divisions had medical battalions, the medical battalion commander directed medical operations. He could move assets as needed without serious regard for a brigade commander's opinion. Today, a staff section in the Division Support Command (DISCOM) called the Division Medical Operations Center (DMOC) directs medical activity in a division. This staff section has no command authority and can only recommend actions to the DISCOM commander. If resources have to be reallocated on the battlefield, the DISCOM commander directs it through the FSB commanders. This frequently conflicts with the supported brigade commander's wants. When DISCOMs attach FSBs to brigade task forces, movement of these assets becomes a difficult task, at best. Timeliness is critical to treatment of the wounded. This type of coordination and conflict takes too much time and can cost lives.

The FSB idea has created other problems affecting readiness:

- a. Medical units do not train together and learn inter-operability and mutual support.
- b. There is no single center of expertise to advise the commanders. (Division surgeons, due to lack of training have frequently failed in this function.)⁴
- c. There is no principal mentor for junior AMEDD officers in the division. This results in a failure to learn techniques that no one has recorded in any manual, but pass from senior field medic to junior field medic like folk lore.

d. Finally, there is no commander with the single mission focus of caring for the sick and wounded.

Although the wounded are not concerned with what type of system cares for them, they do worry about getting the best and the fastest care possible. This is not possible in the current multi-functional environment with conflicting priorities and no devoted medical command structure. American soldiers deserve a single, dedicated system to treat and evacuate them when they become sick or wounded. They deserve a system in which they are the priority in the commander's eyes; not intermixed with food, fuel, ammunition and repair parts. The wounded should not be in competition for scarce transportation resources. The Army feels that communications, chemical, intelligence, and engineer support are so important that each must have its own unique centralized system. How can it fail to recognize that the wounded soldier should have no less?

There are other logistics areas where the dilution of functional systems should be subject for review. The user community identified two during Operations Desert Shield and Desert Storm. These were transport and Class IX repair parts. The FSB doctrine that spread transportation assets around the division did not provide sufficient movement assets to anyone. Effective movement of personnel and materiel requires central control and consolidation of assets, attributes not part of the multi-functional concept. Effective management of repair parts is difficult. It is labor intensive. Responsive management requires a single overview of the location and availability of the needed parts. Only a centralized system can ensure that what is available goes to the unit with the greatest need.

This leads to the thrust of this paper. A shortfall of the multi-functional system is the loss of training and mentoring that junior and inexperienced AMEDD officers require to succeed in

divisional assignments. If no MSC lieutenant colonel and staff are available to teach junior officers and inexperienced senior officers (such as division surgeons) in the art of field medical operations, then such instruction must come from other sources. The Army recognizes the value of mentoring, coaching and "foot locker" counseling as highly effective means of training and development. They have even become part of Army doctrine. The loss of this ability means that the Army must employ another system to provide effective AMEDD officers to divisions.

THE STUDY AND FINDINGS

I. WHAT SKILLS, KNOWLEDGE AND ATTITUDES ARE NEEDED?

There are several lists of the skills, knowledge and attitudes (SKA) universally required of officers. A comprehensive list of SKA required of Medical Service Corps (MSC) officers in the 67H career field (Medical Plans, Operations, Training, Security and Intelligence Officer) appears at Appendix A. Its author directed it at a relatively narrow section of the MSC. However, the Medical Service Corps leadership sees it as a general guide for selecting AMEDD officers for division assignments. (The Consultant to the Surgeon General for Plans, Operations Training, Security and Intelligence fully considered these assignments when he compiled the list.)⁵ The Academy of Health Sciences (AHS) developed courses to meet these SKA requirements in the Officer Basic Course (OBC) and the Officer Advance Course (OAC).

The AHS added courses to develop functional skills not identified in the 67H list. These functional skills are more applied in nature than the first list demands. This satisfies somewhat the needs of officers in divisional assignments. Like the output of many other military schools, most of the courses provide familiarity not proficiency. Training and Doctrine Command

(TRADOC) expects proficiency to be developed in unit assignments. This is as true for the Armor lieutenant as it is for the MSC lieutenant. The difference is that the Armor lieutenant has many mentors available to him in the armored division, the MSC has virtually none.

The list of core courses and specialty track courses for OBC and OAC appears at Appendices B and C respectively. For this study, the author selected a condensed list, one aimed at the functions required in medical companies, platoons and sections. This list appears below:

AMEDD Officer Skills and Knowledge Required in Divisions

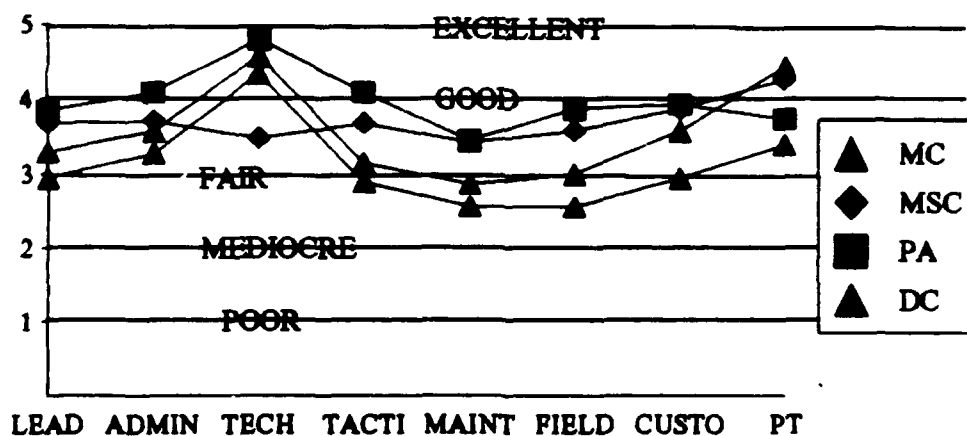
- a. Leadership - the ability to lead and motivate soldiers.
- b. Administrative - knowledge of Army forms, format, and procedures.
- c. Technical - knowledge of medical procedures, preventive medicine, field sanitation, etc.
- d. Tactical - knowledge of supported unit tactics, ability to deploy and employ medical unit support.
- e. Maintenance - knowledge of common maintenance procedures, Preventive Maintenance Checks and Services (PMCS), forms, etc.
- f. Field Craft - survival, escape and evasion techniques, living in the field, map reading and land navigation, other related skills.
- g. Customs and Courtesies - knowledge of drill and ceremonies, protocol, military courtesy, proper wearing of the uniform, etc.
- h. Physical Condition - ability to pass the Army Physical Fitness Test, achieve unit standards in road marches, runs, etc.

II. HOW DO AMEDD OFFICERS PERFORM NOW?

The author took a survey of one hundred line officers, former battalion commanders attending the Army War College, Class of 1992. The eight areas listed above formed the basis of the questionnaire. A copy of the questionnaire appears at Appendix D. Eighty-three officers responded, fifty-two of whom had AMEDD officers assigned to their units in the following quantities: 18 Medical Corps (MC), 31 Medical Service Corps (MSC), 45 Physician Assistants (PA), and 7 Dental Corps (DC). The author developed an average for each type of officer in each category. It appears at Appendix E. The chart below plots out the results:

AMEDD OFFICER PERFORMANCE IN DIVISIONS

SURVEY OF 100 FORMER COMMANDERS AT USAWC



The data represented is not statistically significant. The sample size was too small and the standard deviation was too large. However, the information does have practical significance. It shows areas of concern about which the battalion commanders felt strongly. Their concerns formed the basis for the author's recommendations.

III. ANALYSIS

The Physician's Assistant (PA) was the clear leader in all categories but one. This is probably due to several factors:

- a. extensive enlisted experience with its enclosed knowledge of Army requirements;
- b. leadership skills;
- c. extensive medical training;
- d. immediate availability to the commander; and
- e. an inherent dedication to the Army, the unit and the commander's wishes.

The PA even enjoyed a higher level of confidence in technical (medical) skills than the Medical Corps officer. This is probably due to more exposure and more personal contact with the battalion commander than the physician enjoyed. The PA's most consistent failing was in physical fitness. This may be due to the advanced age of most PAs or more pressing clinical duties that kept the PAs from participating in regular physical training events. They may have had an attitude that physical prowess was unnecessary.

On the average, the Medical Service Corps officers fared second of the four types of officers rated. Comments ranged from, "the finest officer in my battalion" to "a total dud, now out of the Army." It appears that more officers fell toward the former category than the latter. The survey suggested that only four out of the thirty one MSC officers represented rated poor to mediocre in most of the categories. The MSC's largest shortfalls came in knowledge of Army maintenance procedures. Overall, though, the commanders consistently rated the MSC as "Good."

Dental Corps officers ranked third, though the sample size was very small. However, the responses were sufficiently consistent to add credence to their representation. Personal

experience with dental officers in maneuver units has always been positive. DC officers perceive that those who perform well in field units have an advantage over dentists who have not served with the line. The Dental Corps implies this philosophy in its assignment and school selection policy. Although DC opportunities for service in field units are more limited than other AMEDD branches (except Army Medical Specialist Corps and Veterinary Corps) they perform with consistent zeal and enthusiasm. The author feels this enthusiasm is the key to their success. Further, evaluation of some skills and knowledge is really not applicable to dental officers. They have essentially no tactical nor maintenance responsibilities and rarely have the opportunity to go to the field. The only units available for them to command are dental detachments at the corps-level and above. Yet, according to the commanders, they genuinely appreciated their dentists' field service. This is a key point. The line officers surveyed really valued the dentists' attitude toward their duties.

The AMEDD officers with the least favorable responses were in the Medical Corps. They scored lowest in all areas except technical skills. A few MCs received high marks. Most of those were prior service, US Military Academy graduates, or showed a leaning and enthusiasm for field medical service. The commanders' comments were more critical. They had less to do with a lack of skill than a perceived attitude that the doctors did not belong in field units and did not want to serve there. The physicians preferred hospital duty to field duty, resented the rigors of the field and decried participation in non-medical field training. A major complaint about unit surgeons was the lack of tactical knowledge resulting in poor advice to commanders on the use of medical assets.

One very misunderstood issue is the perceived Army policy that Medical Corps officers be placed into command of medical units during war. This is not a published policy. The fact is

that the Table of Organization and Equipment (TO&E) for most medical units codifies the commander's position as a Medical Corps officer. The provisions of Army Regulation 40-1, paragraph 1-9, direct that when Medical Corps officers are not available for command, the senior AMEDD officer, despite branch affiliation, will assume command. This provision is used in peacetime to free up physicians for clinical duties and allow Medical Service Corps officers to command. Most commanders recommended that physicians not be assigned as platoon leaders or company commanders over the MSC officers who occupied those positions in peacetime. The MC officers are just not as well prepared for the tactical leadership positions.

IV. EDUCATING NON-AMEDD OFFICERS

The battalion commanders were glad they had their medical sections. They felt that the contribution made by medics was a positive factor in troop morale. The medical section or platoon added confidence to soldiers who were going into dangerous training events or combat. The advantage of having medics far outweighed any negative aspects. Taken as a whole, soldiers do not like to go into combat without their medics. The battalion commanders made this quite evident in their responses.

A common shortfall of non-AMEDD line officers is an in-depth understanding of how medics and medical units operate. This leads to unfulfilled expectations, disappointment, frustration and even anger. A frequent misunderstanding stems from the Geneva Conventions that preclude medics from performing any offensive role in combat. For instance, according to the Convention, a medic cannot call in artillery fire, operate machine-guns, mines, mortars or even use a bayonet.⁶ Medical units are lightly armed, with only pistols and rifles for

self-defense and the protection of their patients. Yet because of their size, FSB commanders usually place medical units on the perimeter with the responsibility for guarding a sector of it. Many line officers expect more of their medical units than medics are trained for or are legally allowed to do. This stems from a systemic lack of knowledge of medics, their roles and functions.

The solution to this problem clearly lies in education. The AMEDD and TRADOC must commit the resources to rectify this situation. This means adding or expanding courses to the curricula of Officer Basic Courses and Advanced Courses of the non-AMEDD branches. It is especially important to add or expand courses in Command and General Staff College and pre-command courses where the graduates are more likely to supervise medical units. This is particularly true of Combat Service Support officers (Quartermaster, Ordnance, and Transportation Corps). If an important part of the FSB mission is medical in nature, then medical training should command a more important part of FSB commanders' training.

Additionally, line battalion commanders and their staffs should have a clear understanding of what their medics can and should do for them. The line needs to know the proper way to employ their medics. Unlike their line counterparts, medics have two distinct arenas in which they must work in peace and war: the field and the garrison. Most line officers see any garrison assignment as a filler between troop assignments. They generally deplore non-troop duty. They do not understand that this is not so for medics.

If the Army adopts these training initiatives, only a portion of the problem will be solved. The larger portion, providing AMEDD officers who can and will perform as expected remains a challenge for the Surgeon General and the leadership of the Army Medical Department.

ARMY MEDICAL DEPARTMENT ANSWERS

I. TRAINING

A. GENERAL

The large reduction in the Department of Defense budget and in military personnel end-strengths eliminates the possibility of opening any new, special courses for AMEDD officers going to divisions. The rebirth of the old Battalion Surgeon's Assistance (BSA) Course, a four week segment of training added to the end of OBC is a very difficult option to execute. The Medical Field Service School conducted the course "in war time" to teach Medical Service Corps officers the additional skills needed to run medical platoons and sections. The course was an intensive mixture of tactics, techniques, procedures, and clinical medical skills. The clinical skills taught were much more than mere bandaging and splinting and included such procedures as chest tube insertion, intravenous therapy, suturing and the like. It is unlikely that the Surgeon General can afford to commit the additional resources of money, manpower, and additional student days to add this or any other courses not now planned, to the inventory.

The Combat Casualty Care Course (C4), a two-week course currently given to most physicians, dentists and some MSCs teaches a good mixture of the BSA skills. The AMEDD Assignment Branches should direct that all AMEDD officers going to divisions take this course. This is a very positive step that will enhance the operation of medical sections. The C4 course is divided into two sections: the faculty teaches the clinical part at the Medical Field Service School (MFSS), Fort Sam Houston, Texas (indoors, under clean conditions). It teaches the field portion at Camp Bullis, outside San Antonio, Texas. If the faculty taught the clinical portion at Camp Bullis in tents, it would improve the training and realism significantly. This more accurately

replicates the conditions in which clinicians will perform their skills in combat. Further, the additional field training will answer in part the commanders' expressed concerns about field knowledge of their physicians. In those surroundings, the physicians particularly would gain an appreciation of the environment in which they must work. Commanders seldom set up aid stations and medical clearing companies in fixed facilities. Physicians must learn that they can (and will) operate in conditions much worse than any hospital can present. There is no alternative for this training and experience. These field conditions cannot be duplicated in any building. It is imperative that clinicians train as they will function in combat.⁷ This will do much to defuse the frequently heard argument, "I can't work under these conditions!"

The Academy of Health Sciences has recently added another course to its program, the Division Surgeon's Course. This is in response to the frequent complaints received from division commanders and their staffs about ill-prepared Medical Corps officers sent to division surgeon positions.⁸ The author observed eight division surgeons in four different divisions, in both peace and war. It is his opinion that only two surgeons of the eight had a reasonable idea of roles, missions, functions and techniques in the employment of medical assets. Several of these physicians viewed their jobs as necessary; a stepping stone to greater positions in the AMEDD structure. They lacked real enthusiasm for their tasks. They felt that they were wasting their valuable clinical skills in a position that did not demand much highly specialized clinical expertise. Two division surgeons did know their job and displayed enthusiasm for their tasks. Division commanders, their staffs and peers received these Surgeons exceptionally well. One of these physicians was a prior service line officer, the other was a Reserve Officer Training Corps (ROTC) graduate who enjoyed duty with soldiers, out in the field.

A study done by Colonel Michael Antopol at the request of the Surgeon General in 1988-89, corroborated this opinion. COL Antopol said that Medical Corps officers were not adequately prepared to lead the Army Medical Department. He had four major findings:

- a. MC officers perceive that theirs is primarily a clinical role.
- b. MC officers rarely attend military training.
- c. MC officers lack a well defined career pattern.
- d. MC officers wind up running the AMEDD.

From this he developed seven conclusions:

- a. Current military educational experience in MC officers is lacking.
- b. A multi-track program for the MC is necessary.
- c. OBC and OAC can be shortened.
- d. New courses need to be instituted.
- e. MC involvement at the Academy of Health Sciences needs to be strengthened.
- f. AMEDD leadership should consider the applicability of training MC officers with other corps.
- g. The MC needs a comprehensive training strategy.

COL Antopol recommended developing a Field Surgeon's Course.

B. FIELD EXPERIENCE IS THE BEST TRAINING

By the summer of 1992, there will be only two divisional medical battalions in the Army inventory: one in the 82nd Airborne Division and the other in the 101st Airborne Division (Air Assault). All the other divisional medical battalions will have converted to forward support battalions. The last two will convert in the next year or so. While medical battalions were

around, the conflict between medical battalion commanders and division surgeons was well known. The division surgeon is a member of the commanding general's personal staff. As such, he has close personal contact with him. The surgeon makes recommendations based upon knowledge, training, experience and intuition. Unfortunately, the division surgeon is generally in his first divisional assignment and is unlikely to have ever been in a field unit before he enters this important position. He operates from instinct and intuition far more than from experience or training. His advice is generally out of synchronization with that given by the medical battalion commander.

The medical battalion commander, on the other hand, has had many assignments in the division environment. In order for the Command Selection Board to select him for battalion command, he had to demonstrate the potential for success through outstanding performance in previous field assignments. Most likely, the selectee had led a platoon, commanded a field medical company and worked on a medical battalion staff. He had years of field experience and hands-on knowledge. His view of the world was from an entirely different perspective than that of the division surgeon. This inevitably resulted in conflicting input from the two senior AMEDD officers in the division.

Division commanders and staffs must sort through the conflicts and decide a course of action. Both the division surgeon and the medical battalion commander have valid points, but only one choice should be made, the correct tactical one. This is the medical battalion commander's forte'. He understands tactics, the surgeon more than likely does not. Yet Army doctrine states that the division surgeon is "the single medical resource manager of the division."¹⁰

The common but erroneous notion that only physicians can command medical units in war (discussed earlier) has led to more hostility and frustration than any other.¹¹ Based on this assumption the division surgeon felt that he should have more of a say in the operation of the medical battalion in peacetime training if he was to command it in war. Therefore, he frequently used his position at the commanding general's side to influence activities in the battalion.

Obviously, the medical battalion commander resented this and much friction resulted. He felt like his occupation was only an interim one. He felt that the commanding general expected him to train and prepare his unit for combat and then take him out of command at the critical moment. Many medical battalion commanders negotiated agreements with their commanding generals to preclude this from happening. In Operation Desert Storm, the 82nd Airborne Division retained its MSC battalion commander for combat operations, the 101st Airborne Division did not.

When the 326th Medical Battalion, 101st Airborne Division, deployed for combat, the MSC battalion commander became the executive officer and the division surgeon became commander. The division commanding general made this change based on the erroneous assumption discussed above. The MSC officer was a Master Aviator with several divisional assignments and previous combat service. He was a highly knowledgeable officer with invaluable experience. Yet the division commander replaced him with another officer who was not as well qualified for command of a field unit, but was a physician.

Despite philosophies, it is unwise, even to the casual observer, to capriciously change commanders just as the war starts. What sensible division commander would change a proven line battalion commander on the eve of combat without a very good reason? Yet commanders did this at every level from platoon to corps-level hospital during Desert Shield and Desert Storm

with some disastrous results. A medical brigade commander relieved two hospital commanders for cause, and censured one for failing to provide for the protection of his command. One medical platoon ceased to be effective because of the physician commander's ineptitude.¹²

If Medical Corps officers are to command units in war, then they must be prepared to do so, both by training and assignment. The Division Surgeon's Course is a step in the right direction, but is not enough. Physicians whom OTSG has identified as potential battalion, brigade or division surgeons should attend the Command and Staff Track of the AMEDD Officer Advanced Course, and Command and General Staff College. This is also true for those who are foreseen as possible TO&E hospital commanders, medical company or medical battalion commanders. Additionally, MC officers should go through the centralized board process when selected for command. The current system that selects combat commanders based upon seniority and availability without regard for capability is a recipe for disaster. Once selected, the MC should attend the entire gamut of pre-command courses to include the Senior Officer's Preventive Maintenance Course at Fort Knox, Kentucky. The requirement for a fully trained, experienced and knowledgeable commander does not change with branch.

The junior Medical Service Corps officer is the one AMEDD officer likely to see a divisional assignment early in his career. Also, he is more likely to be put in a dynamic leadership position much earlier than other AMEDD branch junior officers. The stated philosophy of the MSC branch leadership is that it will assign every non-clinical MSC to a field unit as early as possible in his/her career. One Consultant to the Surgeon General says that there is no substitute for this early experiential learning about the Army.¹³ No other forum will teach leadership, maintenance, administration, tactics and operations as well as actually performing such in a real field environment. Senior commanders are far more prone to forgive mistakes

made by inexperienced second lieutenant platoon leaders than those made by poorly prepared captain company commanders. Leaders expect the learning curve at the lowest end of the officer spectrum to be steep, therefore, errors are more readily tolerated. However, they expect a company commander to know his trade, particularly in the multi-functional environment where he is most likely required to be the medical subject matter expert. The success of the medical platoon frequently hinges on the skills of the platoon sergeant, whereas the success of the medical company always hinges on the commander.

C. DIDACTIC TRAINING

The junior MSC officer gets his only formal military training opportunities (less special training like Airborne, Ranger, and Air Assault) in OBC and OAC. The Academy of Health Sciences attempted to develop courses that fit the entire spectrum of AMEDD officer specialties. There are 108 AMEDD specialties, far more to cope with than any other branch school or center. It is a very expensive, if possible task to tailor a single program to serve each specialty. Therefore, AHS developed a strategy of common core courses supplemented by thirteen Specialty Tracks.

In AMEDD OBC and OAC, MFSS divides the academic load into two phases¹⁴. Phase I covers Military Qualification Standards (MQS) I and II core courses that Training and Doctrine Command requires. These classes provide general professional military education and training common to all Army officers. Also in Phase I are the AMEDD core courses, which provide general professional military education and training that all AMEDD officers require. Phase II contains the tracks that are more specialty specific. These courses are not so much clinical in nature (not *how* care is delivered) but teach Army-peculiar systems such as records keeping,

administration, and supply management (delivering care *in an Army facility*). The Academy grouped like specialties into these tracks (e.g., nurses in one track, dentists in another, and physicians and physician assistants in yet another). Unfortunately, only one track has a major field orientation to it, the MSC 67B Track. There are some field topics in the MC/PA and other tracks, but not nearly enough to make these officers acceptably adept in a division.

The Academy designed nearly all these courses to provide "familiarity, not proficiency." This is true in virtually every center and school. TRADOC leaves proficiency level training to the divisions. This is not a problem for combat and combat support specialties such as infantry, signal, engineer, etc. There are several sources of expertise in the divisions to ensure that the young Infantry second lieutenant goes from familiarity to proficiency. However, in the medical arena, there is no expertise in the divisions that have no medical hierarchy.

As previously shown, even the division surgeon lacks the knowledge to teach junior officers to proficiency. Non-AMEDD logistics officers who now find themselves as battalion commanders with organic medical companies are themselves ill-trained and ill-equipped to teach medical tactics, techniques, and procedures to their freshmen AMEDD officers. For want of any other source, the Academy must provide this education.

It is prudent to add some time to current curricula to increase the effectiveness of officers that are going to divisions. Certainly, some courses themselves could be modified. For example, at least four hours of the current core curriculum at AMEDD OBC are directed toward the now-defunct Soviet threat and its weapons systems, and over thirty-three contact hours are directed toward Nuclear, Biological and Chemical Warfare topics. With the threat of nuclear war now greatly diminished, some of these hours should be converted to more generally needed topics. Hours dedicated to such perishable skills as down-wind messages and fallout predictions

are superfluous. Convert them to Maintenance of Equipment or Training. The Academy's Training Evaluation Office should carefully review the curricula with a focus on duty with line units. This will reveal other courses that show an undesirable time-benefit ratio. No doubt, a few courses that have lingered on beyond their usefulness due to academic inertia will go by the wayside.

D. TRAINING TO MAINTAIN

Maintenance is one area that demands more time and more applied skills training. In a speech to the US Army War College, one general officer explained many difficulties in the future regarding sustaining the force. He foretold that modernization of the Army is going to slow due to shrinking resources. This means that the Army will buy fewer and fewer new vehicles and equipment. The Army could return to the days of "The Army of Excellence" (AOE) that was also commonly known as "The Army of Emptiness." Vehicles probably will exceed age and mileage replacement points because the Army cannot afford to purchase new ones. This means that good maintenance will become more important than ever. Medics must provide excellent maintenance as well as tankers and truckers.

The surveyed battalion commanders' most common comment expressed the need for maintenance training in their AMEDD Officers. Few knew how to perform Preventive Maintenance Checks and Services (PMCS) or maintenance and virtually none knew how to do it well. If senior leadership expects an officer to perform with confidence and competence immediately upon joining a unit, the Academy of Health Sciences must prepare him to do so.

The AMEDD must provide the Army with junior officers who are competent maintainers of the standard trucks and tracked vehicles issued to medical units. For example, every MSC

officer leaving basic course should understand operator-level maintenance standards on the M-930 Series of five-ton trucks, tracked ambulances and other common vehicles. It is especially important that he knows the M-990 Series of High Mobility Multi-purpose Wheeled Vehicle (HMMWV): Two-litter and Four-litter Ambulance, and Cargo types. The MSC must know how to do PMCS on each type of vehicle and know how to inspect them to see if their soldiers have properly done it. They must know how to maintain and inspect the M-16 Series rifle, the M-9 and M-1911A1 pistols, and the M-17 Series protective mask. They must be familiar with Army tentage from the GP-Small through the GP-Large; how to clean them, repair them, maintain them and most importantly, how to erect them. Medics should understand basic tool sets, and be familiar with maintenance requirements for all medical and engineer equipment (generators) located in a battalion aid station or forward support medical company, as a minimum.¹⁵

In order for the Academy to provide this training, it must add this equipment and expertise to its teaching repertoire. This is a common practice at other branch schools such as the Armor School at Fort Knox, Kentucky and the Combined Arms Support Command at Fort Lee, Virginia. Maintenance training would be best done in the field, but this may not be possible due to lack of a site. If this is so, then perhaps Fort Sam Houston, Texas could make some older garage or warehouse facilities available to AHS. Previously, it was difficult for the Academy to obtain such equipment. Now, with the down-sizing of the Army and the return of units and equipment from forward deployed areas, sufficient resources should become available for lateral transfer to AHS.

E. TRAINING TO TRAIN

"The Army must train as it fights."¹⁶ The fact is that it will fight as it has trained. In the last fifteen years, the Army has trained a hundred times more than it has fought. The schools should prepare their officers to train to fight. In other words, schools should educate their officer output on How to Train with an eye toward fighting. They should not just train their officer output to fight with training as an afterthought.

It is no wonder that soldiers get bored with training. Much of it is repetitive and unchallenging. There are two reasons for this. First, many leaders do not know how to teach or train their people. Second, good training takes about four times as much time to prepare than to deliver. In today's Army, there are so many administrative requirements and minutia that there is little quality time available for the preparation of training. Also, the pressure is on commanders to train all the time. The only exception is maintenance. Commanders use some training time for maintenance ("Training and maintenance are inseparable.")¹⁷ However, training preparation must be done concurrently with other activities. The result is often mediocre training; poorly prepared, poorly delivered.

Training conditions are even tougher in the combat service support units. CSS units have dual functions. When in garrison, they provide the division with maintenance, supply, transportation, and medical support. Their day-to-day activities are mission related from a technical perspective. Unfortunately, to gain tactical proficiency, these units must train in the field. This results in either interrupted garrison support if the entire unit deploys to the field, or at best, reduced support if only part of the unit deploys. The latter case is the worst one for the CSS battalion commander. It gives him and his superiors the illusion that his unit has trained on field skills when in fact, only a part of the unit went to the field. This is particularly true of

medical units. Installation health care support is frequently dependent upon borrowed military manpower. Take the TO&E medics to the field and the installation medical treatment facility must reduce services or increase waiting times. This results in complaints from soldiers and dependents to the post commander. This has a cascading effect that usually leaves the medical company commander with very limited opportunities to take his entire unit to the field. With such limited field training time available, medical unit leaders must know how to optimize their opportunities and provide first quality training.

The Academy's core course offers six contact hours on Training to Basic Course officers and the same to Advanced Course attendants. A mere six hours dedicated to the major task facing any officer is short-sighted to say the least. It requires more time than that just to understand the Army's METL-based (Mission Essential Task List) training philosophy. The full spectrum of training management, enumerated below, requires a certain expertise. The elements of training management are:

- a. developing the Mission Essential Task List;
- b. deciding critical individual, collective, and leader skills;
- c. developing empirical performance assessment methods;
- d. designing, developing and resourcing training events to ensure proficiency at the individual and unit level.
- e. assessment of the training outcome; and
- f. feedback and reassessment of training preparation and execution.

Six hours are not enough to develop this expertise.

Training is not a requirement that is unique to field units. Training is a universal requirement at every echelon in the Army. The Army is introducing new systems that require

training of operators at all levels, be they military or civilian. This is especially true in this age of computers, high technology, and sophisticated weapons systems. Therefore, the need for good training techniques has never been more evident.

Every specialty in the AMEDD has an inherent training mission. Some training is very technical and specialized such as medical residency training (like neurosurgery). Other training is more general and universal, such as basic First Aid or Common Task Training. Nonetheless, there is an obligation for all officers to be able to plan and deliver quality instruction, whatever branch. This universal requirement demands a greater commitment by the Academy to provide formal instruction in training. The Faculty Development Unit (FDU) at the Academy of Health Sciences exists solely to train the trainers who will teach there. FDU must expand its role and develop a program that teaches this art and science to every OAC and OBC attendant. Additionally, the faculty should present a refresher on techniques and methodologies to the AMEDD Pre-Command Course. Obviously the dis-jointed six hours the Academy now teaches is insufficient. At least twelve to twenty contact hours including practical exercises are a minimum needed.

F. TRAINING TO LEAD

Are Leaders made or born? That is a question that has led the pursuit of leadership definition, catalogues of qualities and examples, and a virtual endless stream of theories and philosophies. Perry M. Smith, in his book Taking Charge, lists twenty key fundamentals to good leadership. If only it were that simple. Each generation has brought a new idea and the Army adds them to its repertoire. The Army continues to search for that certain vehicle that will enable

it to develop the perfect leader out of every officer and non-commissioned officer that it trains. Unfortunately, this is not so yet. The search continues.

Fortunately, AHS has recognized the importance of leadership and has devoted many contact hours in OBC and OAC to the topic. However, the battalion commanders surveyed made sufficient comment on weak leadership in the AMEDD ranks, particularly among the physicians and dentists, to warrant addressing the issue here. The reasons for weak leadership in the MC and DC are not generally attributable to those professions as such. Speculation has it that the MC and DC assigned to divisions are on unfamiliar turf and are therefore unlikely to assert themselves. Certainly the physician has no problem being in charge in the clinical setting or the operating room. This is equally true for the dentist. It seems to be the line or field environment that intimidates them and diminishes the confidence required to be a dynamic leader. This can only be overcome by making the MC and DC officer more knowledgeable of and therefore, more comfortable in the TO&E environment. Training and experience do this best.

MC and DC officers identified as potential division surgeons and dentists in forward support medical companies should, beyond attending the courses previously recommended, spend some time working in the field environment. The Surgeon General should adopt a policy that more aggressively supports field training exercises. He should require more Professional Officer Filler (PROFIS) physicians and dentists to attend field training events, especially at the National Training Center and the Joint Readiness Training Center. To enhance camaraderie, the PROFIS should go with the units with which Health Services Command aligns them. These opportunities will give them the confidence, experience, and training that will prepare them for more dynamic roles in TO&E assignments.

G. NEW TRAINING METHODS

All United States Military Academy (USMA) cadets, ROTC students and officer candidates will satisfactorily perform the tasks contained in the Military Qualification Standards (MQS) I as a prerequisite for attending Officer Basic Courses.¹⁸ This requires USMA, ROTC, and OCS to prepare incoming officers so that resident training at OBC will not have to cover those topics and therefore can be shortened.

It appears there will be a restructuring of many other courses to reflect the methodology currently employed by the Combined Arms & Services Staff School (CAS¹). Students must successfully complete an extensive non-resident correspondence course before they attend the resident phase. This can be very economical. Courses can be shortened to only the days needed for intensive or special "hands-on" training. This will allow more sessions and more students in a year. The annual cost per student trained will be reduced. Additionally, instructors can be assured that their students have properly prepared by checking their scores on related portions of the correspondence studies. An additional benefit is one of commitment. Students required to complete a non-resident phase as a prerequisite to attending the resident phase tend to be more committed to excellence.

The Academy of Health Sciences should adopt this philosophy. AHS should develop non-resident courses for OBC and OAC attendants as prerequisites. The officers must complete them before going to the resident phase. The Army could require ROTC college seniors and direct commission officers to complete MQS I requirements and an AMEDD basic orientation before attending OBC. Also, the Academy should direct Advanced Course students to complete MQS II requirements and specially developed staff-oriented studies before they arrive at the Academy. These initiatives will not necessarily mean a reduced length of OBC or OAC. They

will allow either more courses to be taught, or hours moved from one course to another. For instance, if the Academy shifted training on military writing to non-resident study, then it could convert those hours to maintenance or field training. If it planned and executed this initiative well, it could achieve both objectives (more topics taught in shorter courses).

One item that will greatly help the medical platoon leader and to some extent, the medical company commander is a "how-to" manual. The Academy has just produced a Medical Platoon Leader's Handbook (FM 8-10-4). It is in approved final draft stage. It is too early to tell how effective it is, but it is a start in the right direction. If it needs modifying, there are many tactics, techniques and procedures that are perfect to publish in such a manual. This guide should tell the new lieutenant how to set up the ideal aid station. It should explain patient traffic flow, how to load and unload an ambulance, radio-telephone procedures, mass casualty management and a myriad of other topics. This manual must be more pragmatic and not as theoretical as other efforts. Such a manual will serve not only to teach the junior officer, but as a ready pocket reference and a guide to training. Its contents will assist platoon leaders to train their units in the art of field medical care and operations.

The Academy has several other manuals in draft. Among these are FM 8-10-1, The Medical Company; and FM 8-10-5, The Brigade and Division Surgeon's Handbook. These efforts can only be an improvement over the void that now exists. These manuals also will serve non-AMEDD officers with command or supervisory responsibility over medical units as a guide to see if their medics are doing things the right way.

Besides the manuals, the Academy should develop more field oriented non-resident courses directed toward officers and NCOs in TO&E assignments. AHS should develop topics to provide a viable continuing education program. These topics would include field medical

operations and management, advanced first aid and field medical treatment, medical equipment inventory and maintenance, and medical logistics. These correspondence courses will maintain currency as new techniques are developed, or as inexperienced officers enter the TO&E arena. Medical platoon leaders, company commanders and NCOs who have been away from formal schooling for some time would find these courses especially beneficial. The Academy already has a Department of Non-Resident Education that could expand and manage this training.

As computers become more common, interactive computer-aided training becomes the state of the art. TRADOC is exploring this concept, which it calls Distributed Training. This idea employs recent technology to enhance the learning experience and improve educational efficacy. Improvements in graphics, to include the ability to add photographic quality images to computer programs make this an ideal medium for teaching. Frequently officers have home computers. By developing the interactive training on commercial systems the Academy would make it more available, user friendly and less expensive. The biggest mistake would be to develop the programs on some Army-special system that no one has and that is difficult to operate. This has been a common downfall of many Army systems.¹⁹

Off-the-shelf programs are much cheaper to adopt and adapt to Army needs than development of programs from scratch. Additionally, it is more economical to produce and distribute computer programs than to print and mail out manuals and tests. Copying disks is much cheaper than printing paper materials. After development, it is an easy task to export a set of disks with a small documentation instruction manual to guide the student through the training. Individuals could request the training, or the individual's supervisor could direct the study. Branch assignment offices could require the student to complete such courses as a condition of transfer to a TO&E position. Additionally, the Academy could distribute sets to each

installation's Soldier Education Center to be checked out by interested officers and NCOs.

Today's soldiers are much more comfortable with computers than any previous generation. No doubt, this familiarity will enhance the effectiveness of the initiative.

II. ASSIGNMENT POLICY

Training and education are not the only answers to the problem of providing quality AMEDD officers with a high probability of success to divisions. The Army must assign the right people to such positions. This next idea may contradict Department of the Army assignment philosophy, but none the less, not everyone belongs in field units. Army policy states an Army officer should be able to serve in any organization in the Army. This may be a valid criterion for non-AMEDD officers, but not necessarily correct for the AMEDD. Before another cry rises about medics being "different," the topic bears some discussion.

Out of the 108 specialties in the AMEDD, TO&Es authorize very few in field units. The Army recruits most AMEDD officers for their specific technical skills. Even among the group that could be assigned to a division, there are certain considerations that would lead a prudent assignment officer to choose not to send certain individuals. Obviously, the Medical Department should use officers in shortage specialties in their clinical area, not in the "General Medical Officer" or "Field Medical Assistant" categories. They should work where their special training will be more beneficial, e.g., an obstetrician should not be a division surgeon, nor should a health facilities planning officer be a medical company commander. They must perform where their special training will contribute the most to the general needs of the Army.

Also, there are officers who really want to serve in field units. These officers have the highest probability of success because they really desire to be with the line. Their appetite will

aid them to learn and perform at a higher level than their counterparts who would much prefer to be in a fixed facility. Further, the relevance of a field assignment to the contribution of a highly specialized officer is small. In short, to serve with troops will not help the officer perform neurosurgery. Also, an officer who resents a field assignment cannot be expected to perform at his optimum level, by that providing poor service to the unit and soiling the reputation of the AMEDD.

How difficult could it be to seek out officers who really love the field side of the Army and ensure that they have full opportunity to serve there throughout their careers? It seems a more intelligent way of doing business. There are doctors who really like to jump out of airplanes and live in the field. Also, there are MSC officers and dentists who find the field assignments exciting and challenging and who truly enjoy time with troops. This does not mean that their service must be exclusively in TO&E assignments; there are other positions that require their field experience to enhance their total AMEDD contribution. Some of these assignments include teaching at the Academy, working in medical research and development, concepts and doctrine, or with higher headquarters. The shrinking Army reduced the requirement for AMEDD officers in TO&E units. This should make it easier to screen officers to find those who truly want field service.

Branch should consider the credentials of an officer before his assignment. All too often, the Army sends an officer to command a company who has not been in a field assignment before, or perhaps has not completed OAC. This is unfair for both the officer and the unit. One suffers from uninformed leadership, and the other suffers from the frustration of unpreparedness.

One solution would be to screen new accessions for their disposition to serve with troops. The AMEDD could earmark those that show a desire to do so with a special skill identifier that

would ease their selection for field assignments. One recipe for success is to keep officers in the types of assignments that they relish. Additionally, a series of similar assignments leads to a heightened level of expertise, as each experience builds upon the previous. The officer is better served as is the unit. If medical support is to be an expert system, then experts must run it. This cannot be the case when an officer serves in a field unit once every six or eight years.

CONCLUSIONS

The Army Medical Department is filled with bright, talented, motivated people who wish to serve their nation and be successful. The vast majority love their work and do it well. The AMEDD is a very positive contributor to the success of the Army in the field, and it will continue to do so. Comments from the survey of former battalion commanders confirm this. It was their common opinion that more could be done. Therefore, a change in training and assignment policy would enhance the AMEDD's goals. The Academy must review and restructure training to provide AMEDD officers with the knowledge and skills they need to be successful with the line. Classroom hours dedicated to no-longer-relevant topics or nice-to-have subjects must be converted to subjects that the dynamics of the new emerging Army demand. AHS must change the emphasis to sharpen the skills that field units need most: training, maintenance, medical operations, and logistics. The Medical Field Service School must bring in experts with previous experience to teach these subjects. The MFSS goal must move from familiarity to proficiency. It must develop new, exportable training packages to maintain field skills and develop new ones. AMEDD officers are often alone in their assignments and must be

the medical expert. They must know their business on the day they arrive because there is no one there to teach them. Therefore, the responsibility for preparing them falls to the education system.

Assignment policy needs revision. The maxim about "the right man for the right job" holds today, more than ever before. The Total Army Personnel Command must screen officers with the right training, experience, and desire for assignments with field units. Then put them where they belong.

Selection for AMEDD commands must be done exactly as other commanders are selected: by board action. The most highly qualified must be selected, no more seniority roster commanders. The Surgeon General must either change the TO&Es that require Medical Corps officers to command medical units in war time, or assign them to command in peace time. If a Medical Service Corps officer commands the unit in peace time, then he should take his unit to war. The Army must stop the practice of swapping out commanders on the eve of battle.

If the Surgeon General adopts these recommendations, the quality of Army Medical Department officers assigned to field units will improve. These changes will increase the respect of the AMEDD in the eyes of the line and ensure that AMEDD officers can perform the mission: "To Conserve the Fighting Strength."

RECOMMENDATIONS

1. Educate all non-AMEDD officers about the Army Medical Department. Expand or add courses to all Branch basic and advanced courses, Command and General Staff College and pre-command courses. Topics should include the missions, functions, roles, responsibilities and constraints of medical units and personnel in field units.
2. Improve medical training at the Combined Arms Support Command, especially for FSB/MSB commanders. Intensify the importance of the medical mission.
3. Improve Medical Service Corps training and assignments to make them competitive for FSB command.
4. Send selected MSC officers to the Combined Logistics Officers Advanced Course (CLOAC).
5. Increase MSC assignments to FSB/MSB staffs to enhance command selection opportunity.
6. Reestablish the Battalion Surgeon Assistants Course or extend the Combat Casualty Care Course (C4) to include additional topics. Send all AMEDD officers pending division assignments. Open the C4 Course to FSB/MSB commanders.
7. Present the entire C4 Course at Camp Bullis, Texas, to include the clinical portions. Place more emphasis on clinical activity under field conditions.
8. Prepare Medical Corps officers for command through training and field assignments.
9. Use the centralized board selection process to select *all* AMEDD commanders.
10. Edit and change Academy of Health Sciences curriculum to reflect division needs. Increase Maintenance training, Leadership training and How to Train training.
11. Secure at least one of each type of vehicle and equipment commonly used by medical units. Include common weapons authorized (M-16, M-1911A1, and M-9 pistol).
12. Adopt a policy that more aggressively supports major field training exercises with PROFIS officers.
13. Develop and adopt correspondence courses as prerequisites to attending OBC and OAC. Include MQS I & II, military writing, and other basic topics.

APPENDIX A
SKILLS, KNOWLEDGE AND ATTITUDES - 67H CAREER FIELD

Initial Phase

Skills

Military Qualifications Standards II
Staff Development
Research Process
Personnel/Unit Marketing Strategies
Time Management
Teaching and Coaching
Delegation
Goal Setting
Leadership
Motivation: Self and Others
Basic Computer Skills
Field Medial Skills
Basic Soldier Skills
Job Area of Concentration (AOC) Skills
Counseling
Problem Solving/Decision Making
Issue Analysis
Effective Resource Management
Effective Oral and Written Communication
Individual Mobilization Readiness

Knowledge

Army/Organization Mission and Philosophy
AMEDD and Corps Organization, Mission
and Philosophy
Mobilization Responsibilities
Speciality and Position Competence
Management Process
Military Customs and Courtesy
UCMJ/Military Justice System
Group Dynamics
Professional Development Opportunities
Unit/Division Level Medical Support System

Attitudes

Integrity
"Can Do" Attitude
Accept Responsibility
Lead by Example
Concern for Others/Compassion
Willingness to Listen/Learn

Attitudes (continued)

Selflessness/Dedication/Devotion
Flexibility
Respectfulness
Professionalism
Service

Intermediate Phase

Skills

AOC Proficiency
Communication/Counseling
Motivation of Subordinates
Wartime and Peacetime roles (Army and
AMEDD)
Problem Solving/Decision Making
Sharing Knowledge
Personal Influence/Motivation
Leadership/Management
Initiative
Decisiveness/Judgement
Goal Setting
Time Management
Delegation
Meeting Management
Team Building

Knowledge

Military Systems
Military Medical Systems, TOE and TDA
Mobilization/Readiness Requirements
Resource Management Processes
Group Dynamics
Interpersonal Relations
Self-Awareness
Staff Functions
AirLand Battle Doctrine
Leadership Doctrine
Teaching/Mentorship Principles

Attitudes

Accept Responsibility
Learning from Others

Intermediate Phase (Continued)

Attitudes (Continued)

Caring/ Compassion
Self-Development
Mentoring
Integrity/Ethics
Develop Others
Lead by Example
Commitment to Mission
Service

Advanced Phase

Skills

Meeting Management
Delegation
Negotiation Skills
Implementation of Organization Mobilization
Readiness
Strategies
Executive Writing Skills
Time Management at Organization Level
Clinical/Administrative Expertise in Area of
Concentration
Unit Level Leadership Skills
Mentoring

Knowledge

Command and Staff Roles
Professional Development Opportunities
Army, AMEDD, and Sister Service Medical
Organizations and Missions
Goals, Philosophy, and Mission of the Army
and AMEDD
Mobilization/Readiness Plan

Attitudes

Integrity/Ethics
Proactive and Innovative
Trust in Subordinates and Superiors
Open to Innovation
Allow Subordinates to Grow
Sensitive to Political Environment and Impact
Sensitive to Environmental Concerns
Seek Counsel

Customer/Patient Satisfaction
Holistic Perspective
Confidence and Competence
Lead by Example
Service

Senior Executive Phase

Skills

Ownership for Decision Making
Executive Mentorship
Army Strategic Planning
Diplomatic, Global Focus
Marketing for the AMEDD and Corps
An Expert in Specific AOC
Resource Integration/Management
Long Range Planning
Decisiveness/Judgment
Develop AMEDD Politics to Meet Army
Strategies
Develop Healthy Command Climate

Knowledge

Mission Philosophy and Goals of the Army
Joint Operation
World Affairs/Geopolitics
National Strategy
Principles of All Echelons of Health Care in
Peace and War
Management Principles for National Level
Organizations
Combat, Combat Support and Combat Service
Support Doctrine

Attitudes

Integrity/Ethics
Holistic Perspective
Political Awareness
Open Mindedness
Mentor/Teacher
Listen/Learn
Earn Respect
Leader/Decision maker
"The Buck Stops Here"
Service

Key Leader Positions

Initial Phase

Platoon Leader
Company Executive Officer
Adjutant
Motor Officer
Unit Supply Officer
Battalion Assistant S-2/3
Aide de Camp

Intermediate Phase

Company Commander
Battalion Executive Officer
Battalion S-2/3
MEDDAC Plans, Operations and Security
Officer
Doctrine Developer
Combat Developer
Training Developer
Joint Medical Planning Officer
Reserve Component Advisor
Staff Officer, MACOM, Division, Brigade
Aide de Camp

Advanced Phase

Battalion Commander
Executive Officer, Group, Brigade, DISCOM,
Corps Surgeon's Office
Instructor, Service School
Reserve Component Advisor Branch or Team
Chief
Joint Duty Staff Officer
Senior Staff Position in Division, Corps, DoD,
HQDA,
OTSG Director, Doctrine, Training and
Combat Developments Directorates
Deputy Director,
MACOM or HQDA Staff Directorate

Senior Executive Phase

Chief, Medical Service Corps
Assistant Chief, Medical Service Corps
Commander, Brigade, Group, DISCOM
Deputy Chief or Staff for Plans, Operations
and Training
Consultant, OTSG or MACOM
Senior Medical Advisor, HQDA or Army
Senior Service College Instructor
Deputy Commandant, AHS
Assistant Commandant, AHS
Assistant Dean, Medical Field Service School
Director, MACOM or HQDA Staff
Directorate
Chief or Staff, Medical MACOM

APPENDIX B
ACADEMIC SUBJECTS - AMEDD OFFICER BASIC COURSE

AMEDD OFFICER BASIC COURSE (6-8-C20)

Peacetime: 59 Periods

Mobilization: 61 Periods

<u>Division and Subject or Annex & Subject</u>	<u>Periods</u>	
	<u>Peace</u>	<u>Mob</u>
<u>Behavioral Science Division</u>	(2)	(2)
Combat Stress Reactions and Battle Fatigue	2	2
<u>Health Care Administration Division</u>	(9)	(9)
Post and Installation Support	1	0
Meetings and Briefings	2	0
Military Criminal Law	5	5
Law of War	1	4
<u>Military Science Division</u>	(32)	(32)
Uniform Orientation	3	3
Transition to Officership	2	2
Airland Battle	2	2
The Branches of the US Army	2	0
Introduction to the Threat	2	2
Command and Staff Functions	1	1
Organization of the US Army	1	1
Radio-telephone Procedures	1	1
Communication Electronic Operation Instruction CEOI/COMSEC	2	2
Physical Fitness Program	2	2
The Army's Training Philosophy	2	2
Squad Movement	2	8
Drill and Ceremonies	6	3
Customs & Traditions of the Service	2	2
Role of the Noncommissioned Officer	1	1
Introduction Reserve Components	1	0
<u>Preventive Medicine Division</u>	(16)	(18)
Medical Threat to Field Forces	2	2
Chemical Agents	2	4
Chemical Agents Detection	1	1
Mission-Oriented Protective Posture (MOPP)	3	3
NBC Decontamination	2	2
Climatic Injury Control	1	1
NBC Field Training Exercise	4	4
Army Safety Program	1	1

ACADEMIC SUBJECTS (TRADOC CORE) (MQS II)
 AMEDD OFFICER BASIC COURSE (6-8-C20)

Peacetime: 122 Periods
 Mobilization: 120 Periods

<u>Division and Subject or Annex & Subject</u>	<u>Periods</u>	
	<u>Peace</u>	<u>Mob</u>
<u>Behavioral Science Division</u>	(21)	(21)
Evaluating and Building the Cohesive Team	5	5
Terrorism Countermeasures	2	2
Leader as a Counselor	5	5
The Army Alcohol and Drug Abuse Prevention and Control Program	2	1
Stress Management	2	4
Military Lifestyles	2	1
Army Equal Opportunity Program	1	1
Psychological Aspects of NBC Defense	2	2
<u>Health Care Administration Division</u>	(56)	(52)
Introduction to Supply	1	1
Property Control at the User/Supervisor Level	2	2
Unit Activity Budgeting	3	2
Foundations of the Profession	3	3
Duties, Responsibilities, and Authority	1	2
Introduction to the Profession of Arms and Leadership Doctrine	1	2
Group Dynamics	2	1
Leader Styles	2	2
Leadership that Directs	2	2
Leadership that Implements	1	1
Institutional Pressures (Avenues of Legitimate Dissent)	2	4
Leadership that Motivates	2	2
Setting the Example	1	1
Unit Assessment	2	1
Battlefield Leadership	1	4
Enlisted Promotion and Reduction	1	1
Civilian Personnel Management	2	1
Communications	4	4
Packaging and Prewriting	2	2
Introduction to the Army Writing Program	2	2
Paragraphs and Sentences	2	0
Using Words Effectively	2	0
Editing Techniques	2	0
Special Cases: Awards and OER's	2	2
Practical Exercising in Writing	1	1

<u>Division and Subject or Annex & Subject</u>	<u>Periods</u>	
	<u>Peace</u>	<u>Mob</u>
The 1949 Geneva Conventions on Wounded and Sick	2	4
Officer Evaluation Report	3	1
Enlisted Evaluation System	2	1
Leadership Assessment Program I	2	2
Leadership Assessment Program II	1	1
<u>Military Science Division</u>		
The Soviet Threat	2	4
Military Operations on Urbanized Terrain (MOUT)	2	2
Equipment of the Threat	1	1
Plan and Conduct Rear Operations	2	2
Security	1	1
Medical Intelligence	1	1
Health Service Support: Army Divisions	2	2
Electronic Counter-Countermeasures (ECCM)	1	1
Map Reading Techniques	4	4
Operational Terms & Graphics	3	3
Training the Force	3	3
<u>Preventive Medicine Division</u>	(23)	(23)
Nuclear Weapons Effects	2	2
Radiation on the Battlefield	1	1
Radiation Injury	1	1
Radiation Detection Monitoring and Survey	2	2
Radiation Dose and Dose Decay	1	1
Fallout Prediction	3	3
Chemical Biological Hazard Prediction	2	2
Biological Agents	2	2
NBC Reports	3	3
Unit NBC Defense Training	1	1
Operation Exposure Guide	1	1
Medical Effects of Laser, Microwave and Directed Energy Radiation	2	2
Radiation Shielding and Shelter	1	1
Hasty and Deliberate Smoke Operation	1	1

ACADEMIC SUBJECTS (AMEDD CORE)
AMEDD OFFICER BASIC COURSE (6-8-C20)

Peacetime: 154 Periods

Mobilization: 139 Periods

<u>Division and Subject or Annex & Subject</u>	<u>Periods</u>	
	<u>Peace</u>	<u>Mob</u>
<u>Dental Science Division</u>	(1)	(0)
Army Dental Care System	1	0
<u>Health Care Administration Division</u>	(44)	(40)
Issues and Turn-In Procedures	4	5
Biomedical Equipment Maintenance Management	1	1
Management of Medical Equipment Sets	4	4
Hospital Organization for Logistics	1	1
Manpower Management	4	2
Organization and Delivery of AMEDD Health Care Services	1	1
Health Care Entitlements	2	2
Line of Duty	1	1
Organization and Functions of the Patient Administration Division	1	1
Army Medical Records	1	1
Leader Teacher	1	1
Disposition of the Medically Unfit	1	1
Disposition of the Deceased	2	2
Department of the Army Administrative Publications	1	1
Standard Installation/Division Personnel System (SIDPERS)	1	1
Authorized Absences	1	1
Wartime Unit Personnel Support	1	1
Administrative Separations	1	1
Classification and Assignment	1	1
Officer Personnel Management System	3	3
Labor-Management Relations	2	2
Missouri College English Test	2	0
Informal Investigation under AR 15-6	1	1
Standards of Conduct	2	1
Government Information Practices (Freedom of Information Act) (FOIA) and Privacy Acts (PA)	1	1
International Law/Status of Forces Agreement	1	1
Medical Legal Issues	2	2

<u>Division and Subject or Annex & Subject</u>	<u>Periods</u>	
	<u>Peace</u>	<u>Mob</u>
<u>Medical and Surgery Division</u>	(3)	(3)
Hearing Conservation	1	1
Role of the Physician Assistant	1	1
Duties of the AMSC Officer	1	1
<u>Military Science Division</u>	(94)	(84)
Organization of Army Divisions	2	2
Low Intensity Conflict	2	2
Fundamentals of Combat and Health Service Support	3	3
Combat Maneuver Battalion	2	2
Combined Arms Warfare	10	10
Division Support Command	2	2
The Unit Status Reporting System	2	2
Organization of CONUS Installation	1	1
The Army Authorization Document System (TADDS)	3	3
U.S. Army Logistic System	1	3
Health Service Support: Corps/COMMZ	2	2
Health Service Support: Operational Concepts	1	1
Medical Regulating (Mobilization Only)	0	2
The American Revolution-Military Medical History	1	0
Military Medical Issues of the Civil War	1	0
Introduction to the Combat Service Support	1	1
AMEDD Museum Tour	1	1
The Modular Medical Support System	1	1
Litter Obstacle Course	4	3
Medical Evacuation in Combat Zone	2	4
Leadership Field Exercise (LFE)	18	12
Survival, Evasion, Resistance, Escape and Code of Conduct	1	1
Common Task Test (CTT)	8	8
The Spanish American War	1	0
Qualification Pistol	12	6
Land Navigation	8	8
Small Arms Mechanical Training	2	2
The Army Maintenance System	1	1
USAF Aeromedical Evacuation	1	1
<u>Nursing Science Division</u>	(1)	(1)
Role of the Army Nurse Corps	1	1

<u>Division and Subject or Annex & Subject</u>	<u>Periods</u>	
	<u>Peace</u>	<u>Mob</u>
<u>Preventive Medicine Division</u>	(10)	(10)
Military Medical Entomology and Field Controls	2	2
U.S. Army Occupational Safety and Health Program	1	1
Introduction to Military Preventive Medicine	1	1
Sexually Transmitted Diseases	1	1
Acquired Immune Deficiency Syndrome (AIDS)	1	1
Introduction to the Integrated Battlefield/ Soviet and Warsaw Pact NBC Capabilities	2	2
Management of NBC Contaminated Casualties	1	1
Low Level Ionizing Radiation	1	1
<u>Veterinary Science Division</u>	(1)	(1)
Veterinary Service Theater of Operations	1	1

APPENDIX C
ACADEMIC SUBJECTS - AMEDD OFFICER ADVANCED COURSE

AMEDD OFFICER ADVANCED COURSE (6-8-C22)

ACADEMIC SUBJECTS (TRADOC CORE)

Peacetime: 189 Periods

Mobilization: None

<u>Division and Subject or Annex & Subject</u>	<u>Periods</u>
<u>Behavioral Science Division</u>	(21)
Drug and Alcohol Abuse	2
Military Life Styles	2
Behavioral and Duty Performance During Combat:	
Psychological Aspects of NBC Defense	2
Combat Stress and Battle Fatigue	2
Human Performance in Continuous Operations	1
Equal Opportunity	1
Terrorism/Counteraction	3
Leadership Counseling Program	3
Team Building and Unit Cohesion	5
<u>Health Care Administration Division</u>	(74)
Introduction to Leadership	1
Values and Ethical Decision Making	3
Law of Land Warfare I and II	5
Situational Leadership	2
Leadership that Motivates	3
Communicating as a Captain	2
Mentorship	1
Decision Making I	2
Decision Making II	4
Command Climate	2
Taking Charge	2
Duties, Responsibilities, and Authority	4
Conclusion of Leadership - Putting it All Together	1
Standards of Conduct	3
Law of War	1
Property Control at User Level	2
Issue and Turn-In Procedures	3
Missouri College English Test	2
Introduction to the Army Writing Program	2
Packaging and Prewriting	2
Sentences and "Your Attitude"	2
Using Words Effectively	2
Editing Techniques	2

<u>Division and Subjects or Annex and Subject</u>	<u>Periods</u>
<u>Health Care Administration Division (Cont)</u>	
Writing OERs and Writing with Positive Emphasis	2
Practical Exercise in Writing	4
Military Justice	5
Inventory Procedures and Adjustments to Supply Records	3
Wartime Unit Personal Support	3
Food Service Operations	2
Supervise and Review the Maintenance of Unit Prescribed Load List (PLL)	2
<u>Military Science Division</u>	(70)
ALB Doctrine	2
U.S. Army Organization and Equipment: Division	3
Decision-Making	1
Introduction to Threat	2
Threat	3
Training and Training Management	3
Physical Fitness	2
Fundamentals of Retrograde, Defensive, and Offensive Operations and Health Service Support	3
Low Intensity Conflict	3
Operations Orders	2
Force Integration	2
Rear Battle Operations	2
Electronic Warfare	3
U.S. Army Organization and Equipment: Corps	2
Tactical Intelligence	1
Army Maintenance Doctrine	1
Material Condition Status Report	2
Convoy Operations	1
Movement Planning	2
Military Operations in Urban Terrain (MOUT)	3
Special Operations Forces	2
Organizational Motor Pool Operations	2
U.S. Army Organization and Equipment: Branches	8
Tactical Deception Operations	1
Military History	10
Preventive Maintenance Checks and Services (PMCS)	2
Tactical Air Operations	1
Operations During Obscured Battlefield	1

<u>Division and Subject or Annex & Subject</u>	<u>Periods</u>
<u>Preventive Medicine Division</u>	(24)
Operations in Chemical Hazard Areas	8
Operations in Biological Hazard Areas	4
Operations in Nuclear Hazard Areas	8
Medical Effects of Lasers/Microwave/DE	2
U.S. and NATO Nuclear and Chemical Capabilities	1
Introduction to the Integrated Battlefield (Airland Battle)	1

ACADEMIC SUBJECTS (AMEDD CORE)

Peacetime: 381 Periods

Mobilization: None

<u>Division and Subject or Annex & Subject</u>	<u>Periods</u>
<u>Behavioral and Science Division</u>	(4)
Army Family Advocacy Program	2
Stress Management	2
<u>Dental Science Division</u>	(2)
Army Preventive Dentistry Program	1
The Army Dental Care System	1
<u>Health Care Administration Division</u>	(113)
Enlisted Personnel Management	2
Quality Assurance	2
Civilian Personnel Management	2
Geneva Convention	1
Communication: Introduction	2
Communication/Leadership Profiles	2
Listening: Another Dimension of Communication	2
Impromptu Speeches	3
Introduction to the Information Speech/Briefing	1
Information Speeches/Briefing	6
Introduction to the Persuasive Speech/Briefing	1
Persuasive Speeches/Briefing	6
Communications: Summary Class Critique	1
Meetings and Briefings	2

<u>Division and Subject or Annex & Subject</u>	<u>Periods</u>
Resource Management: Planning, Programming, Budgeting and Execution System (PPBES) at Installation Level	3
Organization and Delivery of AMEDD Health Care Services	1
Accreditation of Health Care Facilities	1
Computer Literacy	10
Manpower Management for the Work Center Manager	4
Health Care Entitlements	2
Tort Liability and the Federal Tort Claims Act	2
Medical-Legal Issues	4
Disposition of the Medically Unfit	1
Resource Management: Role of the Comptroller	1
Organization for Logistics in Health Care Facilities	2
Deployable Medical Systems (DEPMEDS)	2
Medical Care Support Equipment (MEDCASE) Program	2
Management of Medical Assemblages	2
Medical Material Quality Assurance Program	1
Labor Management Relations	4
Diagnosis Related Groups (DRG)	4
Direct Health Care Alternatives	1
Patient Administration	2
Status of Forces Agreement (SOFA)	1
The Role of Computers and Information Mgt.	2
Government Information Practices	4
Biomedical Maintenance Management at the User Level	2
Nutrition and Performance	2
AMEDDPAS for Users	2
Health Care Facility Planning	2
Theater Army Medical Management Information System (TAMMIS)	2
Performance Measures and Analysis	1
The Hospital Chaplain	1
Organization and Delivery of Health Care Services:	1
AMEDD and Civilian Sector Comparison	
Officer Personnel Management	5
Death, Dying and Grief	1
Ambulatory Health Care Services	2
Administrative Aspects a of MASCAL	2
<u>Laboratory Science Division</u>	(1)
Blood Management Program	1

<u>Division and Subject or Annex & Subject</u>	<u>Periods</u>
<u>Medicine and Surgery Division</u>	(4)
Duties of the AMSC Officer	2
AMEDD Research and Development	2
<u>Military Science Division</u>	(234)
Health Service Support, Heavy Division	3
Health Service Support, Light Division	1
Health Service Support, Tenets	1
The Modular Medical Support System	1
Mobilization	2
Military Map Reading	4
Introduction to Combat Service Support	1
Combined Arms Warfare	25
Health Service Support, Employment Principles	1
Commander and Staff	1
Medical Evacuation in the Combat Zone	2
Health Service Estimate of the Situation	1
Use of the Staff Officers Field Manual (FM 101-01-1)	1
Radio-telephone Procedures	1
The G-1 and Personnel Functions	1
Division Practical Exercise	20
Corps Level Practical Exercise	36
Health Service Support of Special Environment	2
Field Medical Support (Field PE)	11
Force Planning	4
The Logistics Staff Officer (G-4)	1
Logistics in a Theater of Operations (LOGTO)	2
Medical Regulating	2
Military Medical Intelligence	1
Medical Unit Staff in Operations (MUSIO)	36
DISCOM	2
Security	1
Common Task Test	4
Common Task Trainup	8
Inspector General Issues in Army MTFs	2
The G-2 and Military Intelligence	1
Joint Operation and Training	2
Civil Affairs Operations (G-5)	1
Organization of DOD and DA	1
Leadership Assessment Program (LAP)	6
The Operations Officer (G-3)	1
Operational Terms and Graphics	3

<u>Division and Subject or Annex & Subject</u>	<u>Periods</u>
Navigate with a Map and Compass	4
Organization of CONUS Installation	1
Leader's Field Exercise (Field PE)	9
U.S. Air Force Aeromedical Evacuation	2
Combat Developments	2
Communications Electronics Operations Instruction (CEOI)	2
Health Service Support Corps\COMMZ (Emerging Concepts)	2
Health Service Support Corps/COMMZ	3
Overview of Reserve Components	2
Small Arms Safety	2
Organization and Employment of USAF	1
The Army Authorization Document System	3
Unit Status Reporting	3
Uniforms Update	1
Qualifications Firing .45 Cal. Pistol (PE)	4
<u>Nursing Science Division</u>	(2)
Role and Responsibilities of ANC Officers in TO&E Units	2
<u>Preventive Medicine Division</u>	(20)
Role of the AMEDD on the Integrated Battlefield	1
Radiation Injury on the Battlefield	2
NBC Field Exercise	4
Medical Threat to Field Forces	2
Preventive Medicine Operations at Fixed Installations	1
Management of NBC Casualties	4
Medical Operations on the Integrated Battlefield	4
Low Level Ionizing Radiation	1
Military Occupational Health	1
<u>Veterinary Science Division</u>	(1)
Veterinary Services Theater of Operations	1

APPENDIX D
BATTALION COMMANDERS SURVEY

AMEDD OFFICER TRAINING QUESTIONNAIRE

1. Which of the following did you have in your battalion:

- _____ Medical Section
- _____ Medical Platoon
- _____ Medical Company
- _____ Other (specify) _____
- _____ No organic medical support

2. Did you have: (Check all that apply)

- _____ Medical Corps (MC) officer (Battalion Surgeon, Flight Surgeon, etc.)
- _____ Medical Service Corps (MSC) officer
- _____ Physician Assistant (PA)
- _____ Dental Corps (DC) officer
- _____ None

(Only if you had NO organic medical support or NO AMEDD officers in your battalion, STOP. Return the survey.)

3. Please rate your AMEDD officers on the following characteristics. Please use the 5-point scale below. Rate your Medical Corps (MC), Medical Service Corps (MSC), Dental Corps (DC) and/or Physician Assistants (PA) officers if you had any serving in your battalion. Place a rating from 1 to 5 for each skill or knowledge.

	Poor 1	Mediocre 2	Fair 3	4	Good 5	Excellent	
Skill / Knowledge							
			MC		MSC	DC	PA
Leadership (Lead, Motivate)			_____		_____	_____	_____
Administrative (Format, Procedures)			_____		_____	_____	_____
Technical (Medical)			_____		_____	_____	_____
Tactical (Deploy and employ his unit)			_____		_____	_____	_____
Maintenance (PMCS, Forms, etc.)			_____		_____	_____	_____
Field Craft (Survival, Maps, etc.)			_____		_____	_____	_____
Customs and Courtesies of the Army			_____		_____	_____	_____
Physical Condition			_____		_____	_____	_____

4. If your AMEDD officers performed well (4 or 5) please describe, be specific.

AMEDD OFFICER TRAINING QUESTIONNAIRE

5. If your AMEDD officer did not perform well (1 or 2) please describe and suggest training.

6. Did you give your AMEDD officer additional duties (HHC XO, Preventive Medicine Officer, Mess Officer, etc.) ____ Yes ____ No If yes, what duties?

7. Comments?

APPENDIX E
RESULTS OF THE BATTALION COMMANDERS SURVEY

**RESULTS OF THE BATTALION COMMANDER SURVEY
ON AMEDD OFFICER PERFORMANCE IN DIVISIONS**

AVERAGES

<u>SKILL</u>	<u>MEDICAL CORPS</u>	<u>MEDICAL SERVICE</u>	<u>PHYSICIAN ASSISTANT</u>	<u>DENTAL CORPS</u>
LEADERSHIP	2.89	3.69	3.89	3.29
ADMINISTRATION	3.26	3.72	4.09	3.57
TECHNICAL SKILLS	4.37	3.50	4.81	4.57
TACTICAL SKILLS	2.89	3.72	4.09	3.14
MAINTENANCE	2.53	3.42	3.43	2.86
FIELD SKILLS	2.53	3.59	3.94	3.00
CUSTOMS AND COURTESIES	2.89	3.88	4.00	3.57
PHYSICAL FITNESS	3.63	4.25	3.74	4.43

SCORES

EXCELLENT	5
GOOD	4
FAIR	3
MEDIOCRE	2
POOR	1

ENDNOTES

1. Arthur Bloch, Murphy's Law: and Other Reasons Why Things Go Wrong (Los Angeles, CA: Price Stern Sloan, Inc., 1977), 45.

2. U.S. Department of the Army, Field Manual 100-10: Combat Service Support, (Washington D.C.: 18 February 1988), 3-2.

3. U.S. Department of the Army, Field Manual 8-15: Medical Support in Divisions, Separate Brigades and Armored Cavalry Regiments. (Washington, D.C.: 21 September 1972), 2-5.

4. NOTE: After the relief of two division surgeons and the resignation of a third, the Surgeon General directed COL Michael Antopol, MC, to do a study of Medical Corps Officers. He conducted the study from the Fall of 1988 through the Spring of 1989. COL Antopol found that Medical Corps Officers were not adequately prepared to lead the AMEDD.

Because of the Antopol Study, COL Sam Brown, MSC was directed to develop the Medical Corps Life Cycle (MCLC) Training Strategy Concept. He briefed the concept to the Surgeon General. The effect of the briefing was the development of the Deputy Commander for Clinical Services (DCCS) Course, (now being taught) and the Division Surgeons Course (currently under development).

5. U.S. Department of the Army, Health Services Plans, Operations, Training, Security and Intelligence Officer Professional Development Handbook (Washington, D.C.: September 1991) 5.

6. International Committee of the Red Cross, Protocols Additional to the Geneva Conventions of 12 August 1949, (Geneva: 1977), 13, 21. (Articles 12, 13 and 28.)

7. U.S. Department of the Army, Field Manual 25-4: How to Conduct Training Exercises, (Washington, D.C.: 10 September 1984), 54.

8. See Endnote 4.

9. See Endnote 4.

10. U.S. Department of the Army, Field Manual 100-10: Combat Service Support, (Washington D.C.: 18 February 1988), 3-13.

11. 8- Series Tables of Organization and Equipment define all personnel positions and equipment authorizations for medical units.

12. As Chief of Staff, 44th Medical Brigade, the author witnessed the relief of two Medical Corps Colonel PROFIS commanders. The first created such dissention in his hospital that it ceased to function. The second knowingly allowed drinking in his unit, violating General Order Number One. One Colonel PROFIS commander failed to have his soldiers build bunkers

for defense against artillery and SCUD missiles. The MC platoon leader requested to be relieved and sent back to the States because she did not know how to employ her platoon, move it, or control it. All this occurred during Operation Desert Shield.

13. U.S. Department of the Army, Health Services Plans, Operations, Training, Security and Intelligence Officer Professional Development Handbook (Washington, D.C.: September 1991), Annex C, 13.

14. U.S. Department of the Army, Program of Instruction for 6-8-C20 Army Medical Department Officer Basic Course, (Fort Sam Houston, Texas: 28 August 1990), 3.

15. U.S. Department of the Army, Field Manual 25-100: Training the Force, (Washington, D.C.: 15 November 1988), 1-4.

16. Ibid., 1-3.

17. Gordon R. Sullivan, "A Trained and Ready Army: The Way Ahead," Military Review, (November 1991): 7.

18. U.S. Department of the Army, Army Regulation 351-1: Individual Military Education and Training, (Washington, D.C.: 15 October 1987), 12.

19. A fine example is the Army Dental Workload Reporting System. The concept was developed and demonstrated on a Tandy 2000 computer system using off-the-shelf software. The program was user friendly, easy to run and inexpensive. However, due to centralized contracting and involvement of the Medical Information Systems Management Office at Health Services Command, they procured a non-standard hardware system and let a contract to develop special software. The results were less than satisfactory.

The system was not well integrated which resulted in many hardware failures. The software was so complicated that users had to go to Fort Sam Houston, TX for a week's training before they could use it. Even after that, HSC had to set up a telephone "hot line" for users of the system to solve frequent problems.

Also, Army systems such as SIDPERS, SAARS and SAMMS were all developed on specialized hardware and use non-standard software. Yet the functions that they were designed to perform are being done in major industries across the country using commercially available hardware and software at a much lower cost with greater user ease. The 10th Mountain Division did a concept demonstration of a SIDPERS-like system using Macintosh computers in 1989. It was a great success, but was not adopted by the Army because of the computer moratorium.

In Saudi Arabia, the 44th Medical Brigade used commercially available Laptop and Desk Top Personal Computers with off-the-shelf software to do over 90 percent of its administration. The TACCS was only used to compile and forward SIDPERS and LOG reports. The commercial systems proved to be faster, easier to operate, much smaller and just as reliable as the special Army developed systems.

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U.S. Department of the Army, Program of Instruction for 6-8-C22, Army Medical Department Officer Advanced Course. Fort Sam Houston, Texas: 18 June 1990.

U.S. Department of the Army, Table of Organization and Equipment 8-XXX (various editions). Fort Sam Houston, Texas: various dates depending on version.